		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0017038

Facility Name: Central Plaza Residential Home

Address: 321 N Central (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: 847-441-8200 **Fax #** 847-441-0800

IDPA ID Number: 36-2520668

Date of Initial License for Current Owners: 12/1/63

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rick Duros **Telephone Number:** 847-441-8200

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Rick Duros
(Title) C.F.O.

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	260	Intermediate (ICF)	260	94,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	260	TOTALS	260	94,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	89,612	156		89,768	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	89,612	156		89,768	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.59%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/1/63

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Central Plaza Residential Home # 0017038 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	258,655	36,400	13,480	308,535		308,535		308,535			1
2	Food Purchase		422,600		422,600	(29,812)	392,788	(1,782)	391,006			2
3	Housekeeping	287,112		39,894	327,006		327,006		327,006			3
4	Laundry		32,321		32,321		32,321		32,321			4
5	Heat and Other Utilities			212,454	212,454		212,454	1,765	214,219			5
6	Maintenance	264,487		149,775	414,262		414,262	2,099	416,361			6
7	Other (specify):*											7
8	**TOTAL General Services**	810,254	491,321	415,603	1,717,178	(29,812)	1,687,366	2,082	1,689,448			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,235,675	20,016	10,233	1,265,924		1,265,924		1,265,924			10
10a	Therapy											10a
11	Activities	82,259	16,473	4,840	103,572		103,572		103,572			11
12	Social Services	636,346		527,554	1,163,900		1,163,900	(500,000)	663,900			12
13	Nurse Aide Training											13
14	Program Transportation			263	263		263		263			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,954,280	36,489	542,890	2,533,659		2,533,659	(500,000)	2,033,659			16
	C. General Administration											
17	Administrative	432,380		862,365	1,294,745		1,294,745	(918,751)	375,994			17
18	Directors Fees			240,000	240,000		240,000	(150,000)	90,000			18
19	Professional Services			33,986	33,986		33,986	(27,522)	6,464			19
20	Dues, Fees, Subscriptions & Promotions			26,962	26,962		26,962	44	27,006			20
21	Clerical & General Office Expenses	421,503		(19,464)	402,039		402,039	(16,658)	385,381			21
22	Employee Benefits & Payroll Taxes			647,058	647,058	29,812	676,870		676,870			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,384	3,384		3,384		3,384			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			323,393	323,393		323,393	208	323,601			26
27	Other (specify):*			30,132	30,132		30,132	(26,597)	3,535			27
28	**TOTAL General Administration**	853,883		2,147,816	3,001,699	29,812	3,031,511	(1,139,276)	1,892,235			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,618,417	527,810	3,106,309	7,252,536		7,252,536	(1,637,194)	5,615,342			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Central Plaza Residential Home #0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			85,198	85,198		85,198	17,641	102,839			30
31	Amortization of Pre-Op. & Org.			49,120	49,120		49,120		49,120			31
32	Interest			174,863	174,863		174,863	(54,062)	120,801			32
33	Real Estate Taxes			168,173	168,173		168,173	5,358	173,531			33
34	Rent-Facility & Grounds			35,256	35,256		35,256	(17,827)	17,429			34
35	Rent-Equipment & Vehicles			19,615	19,615		19,615		19,615			35
36	Other (specify):*											36
37	**TOTAL Ownership**			532,225	532,225		532,225	(48,890)	483,335			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,350	142,350		142,350		142,350			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			142,350	142,350		142,350		142,350			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,618,417	527,810	3,780,884	7,927,111		7,927,111	(1,686,084)	6,241,027			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,641	30		9
10	Interest and Other Investment Income	(53,713)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,782)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,592)	21		19
20	Contributions	(22,069)	19		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	99,741	21		24
25	Fund Raising, Advertising and Promotional	(2,815)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(30,132)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,686,048)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,682,769)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,315)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (3,315)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,686,084)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Central Plaza Residential Home

ID# 0017038

Report Period Beginning: 1/1/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Directors Fees	$ (150,000)	18	1
2	Deferred Maintenance	(865)	6	2
3	Management Fees	(862,365)	17	3
4	Risk Management Fee	(6,000)	19	4
5	Misc Income	(241)	21	5
6	Resident Christmas Gifts	(1,250)	21	6
7	Penalties	(2,449)	21	7
8	Non-Allowable Salaries	(56,386)	17	8
9	Non-Allowable Salaries	(106,492)	21	9
10	Community Social Service	(500,000)	12	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,686,048)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Plaza Residential Home # 0017038 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,782)	0	0	0	0	0	0	0	0	0	0	(1,782)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,765	0	0	0	0	0	0	0	0	1,765	5
6	Maintenance	(865)	0	2,964	0	0	0	0	0	0	0	0	2,099	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,647)	0	4,729	0	0	0	0	0	0	0	0	2,082	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(500,000)	0	0	0	0	0	0	0	0	0	0	(500,000)	16
	C. General Administration													
17	Administrative	(918,751)	0	0	0	0	0	0	0	0	0	0	(918,751)	17
18	Directors Fees	(150,000)	0	0	0	0	0	0	0	0	0	0	(150,000)	18
19	Professional Services	(28,069)	0	0	547	0	0	0	0	0	0	0	(27,522)	19
20	Fees, Subscriptions & Promotions	0	0	7	37	0	0	0	0	0	0	0	44	20
21	Clerical & General Office Expenses	(17,098)	0	440	0	0	0	0	0	0	0	0	(16,658)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	208	0	0	0	0	0	0	0	0	208	26
27	Other (specify):*	(30,132)	0	3,535	0	0	0	0	0	0	0	0	(26,597)	27
28	**TOTAL General Administration**	(1,144,050)	0	4,190	584	0	0	0	0	0	0	0	(1,139,276)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,646,697)	0	8,919	584	0	0	0	0	0	0	0	(1,637,194)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Plaza Residential Home # 0017038 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	17,641	0	0	0	0	0	0	0	0	0	0	17,641	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(53,713)	0	0	(349)	0	0	0	0	0	0	0	(54,062)	32
33	Real Estate Taxes	0	0	5,358	0	0	0	0	0	0	0	0	5,358	33
34	Rent-Facility & Grounds	0	0	(17,827)	0	0	0	0	0	0	0	0	(17,827)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(36,072)	0	(12,469)	(349)	0	0	0	0	0	0	0	(48,890)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,682,769)	0	(3,550)	235	0	0	0	0	0	0	0	(1,686,084)	45

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Barton Management Inc	100.00%	$ 1,765	$ 1,765	15
16	V	6	Repairs and Maint		Barton Management Inc		2,964	2,964	16
17	V	20	Dues, Fees, Subscription		Barton Management Inc		7	7	17
18	V	21	Clerical and General		Barton Management Inc		440	440	18
19	V	26	Insurance		Barton Management Inc		208	208	19
20	V	27	Emp. Ben. Gen Admin		Barton Management Inc		3,535	3,535	20
21	V	33	Real Estate Taxes		Barton Management Inc		5,358	5,358	21
22	V	34	Rent Office Space		Barton Management Inc		17,173	17,173	22
23	V								23
24	V								24
25	V								25
26	V	34	Rent	35,000	Barton Management Inc			(35,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 35,000			$ 31,450	$ * (3,550)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	Professional Fees	$	Barton Healthcare LLC	100.00%	$ 547	$ 547	15
16	V		20	Dues, Subscriptions		Barton Healthcare LLC		37	37	16
17	V		32	Interest		Barton Healthcare LLC		170,409	170,409	17
18	V									18
19	V		32	Interest	170,758				(170,758)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 170,758			$ 170,993	$ * 235	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Leon Shlofrock	Stockholder	Administrative	8.24	See Attached	See Attsched		Betcare II	$ 0	17-3	1
2	Joe Magit	President	Admin/Director	0.07	See Attached	See Attsched		Admin Sal	60,000	17-1	2
3	Joe Magit	Director	Director	0.07	See Attached	See Attsched		Director Fee	30,000	18-3	3
4	Irwan Jann	Director	Director	13.93	N/A	1	N/A	Director Fee	30,000	18-3	4
5	Jeff Ross	Relative	Maintenance	0.00	N/A	40	100.00	Maint Salary	70,567	6-1	5
6	Marla Coquillette	Stockholder	Administrative	4.50	See Attached	See Attsched		Admin Sal	47,452	17-1	6
7	John Shlofrock	Stockholder	Administrative	8.80	See Attached	See Attsched		Admin Sal	56,667	17-1	7
8	Elisa Zusman	Stockholder	Office	8.80	See Attached	See Attsched		Office Salary	10,333	21-1	8
9	Jean Shlofrock	Stockholder	Office	0.00	See Attached	See Attsched		Office Salary	10,333	21-1	9
10											10
11											11
12											12
13								TOTAL	$ 315,352		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Barton Healthcare Inc
Street Address: 465 Central Ave
City / State / Zip Code: Northfield, IL
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Note Receivable	29	7	$ 2,925	$	6	$ 547	1
2	20	Dues, Subscriptions	Note Receivable	29	7	200		6	37	2
3	32	Interest	Note Receivable	29	7	910,916		6	170,409	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,041	$		$ 170,993	25

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Barton Management Inc
Street Address: 465 Central Ave
City / State / Zip Code: Northfield, IL 60093
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilites	Rental Income	199,800	8	$ 10,075	$	35,000	$ 1,765	1
2	6	Repairs and Maint	Rental Income	199,800	8	16,921		35,000	2,964	2
3	20	Dues, Fees, Subscription	Rental Income	199,800	8	40		35,000	7	3
4	21	Clerical and General	Rental Income	199,800	8	2,513		35,000	440	4
5	26	Insurance	Rental Income	199,800	8	1,187		35,000	208	5
6	27	Emp. Ben. Gen. Admin	Rental Income	199,800	8	20,177		35,000	3,535	6
7	33	Real Estate Taxes	Rental Income	199,800	8	30,584		35,000	5,358	7
8	34	Rent Office Space	Rental Income	199,800	8	98,036		35,000	17,173	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 179,533	$		$ 31,450	25

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Barton Healthcare LLC	X		Working Capital		1/27/95	$ 5,500,000	$ 3,024,964	demand	variable	$ 170,758	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,500,000	$ 3,024,964			$ 170,758	9
	B. Non-Facility Related*											
10	Shareholder	X		Purchase of Stock	$4,577.00	6/7/00	326,203		7/01	9.5000	4,156	10
11	Interest Income										(52,407)	11
12	Dividend Income										(1,706)	12
13												13
14	TOTAL Non-Facility Related				$4,577.00		$ 326,203	$			$ (49,957)	14
15	TOTALS (line 9+line14)						$ 5,826,203	$ 3,024,964			$ 120,801	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Central Plaza Residential Home # 0017038 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	146,295	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	148,930	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,635	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	170,896	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	173,531	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	157,224	8
	1999	156,169	9
	2000	141,273	10
	2001	146,080	11
	2002	152,822	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Plaza Residential Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0017038

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE 847-441-8200 FAX #: 847-441-0800

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-09-300-011-0000	324 N Pine Ave	$ 414.00	$ 414.00
2.	16-09-300-004-0000	327 N Central Ave	$ 40,065.00	$ 40,065.00
3.	16-09-300-005-0000	321 N Central Ave	$ 106,094.00	$ 103,093.00
4.	Barton Management Alloc	See Attached	$ 61,167.00	$ 5,358.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 207,740.00	$ 148,930.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,310 B. General Construction Type: Exterior Brick Frame _____ Number of Stories Wing#1-5Wing#2-4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: Loan Amortization: $147,452
2. Number of Years Over Which it is Being Amortized: See Attached
3. Current Period Amortization: 49,120
4. Dates Incurred: See Attached

Nature of Costs: See Attached
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	29,048	1974	$ 57,000	1
2	Building-Parking Lot		2001	199,168	2
3	TOTALS	29,048		$ 256,168	3

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	260		1974	1964	$ 385,508	$	30	$	$	$ 385,508	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Additions			1975	303,849		12.5			303,849	9
10	Building Additions			1976	53,526		12.5			53,526	10
11											11
12	Building Additions			1977	47,780		12.5			47,780	12
13	Building Additions			1978	66,037		2.5			66,037	13
14	Building Additions			1979	59,303		12.5			59,303	14
15	Building Additions			1980	24,816		12.5			24,816	15
16											16
17	Building Additions			1980	40,762		3			40,762	17
18	Building Additions			1981	34,255		3			34,255	18
19	Building Additions			1981	10,665		12.5			10,665	19
20	Building Additions			1982	13,492		10			13,482	20
21	Building Additions			1983	48,201		10			13,492	21
22	Building Additions			1984	52,327		10			52,327	22
23	Building Additions			1985	295,316		10			295,316	23
24	Building Additions			1986	144,407		10			144,407	24
25	Building Additions			1987	11,075		10			11,075	25
26	Building Additions			1988	10,240		10			10,240	26
27	Building Additions			1989	39,943		10			39,943	27
28	Building Additions			1990	65,848		10			65,848	28
29	Building Additions			1991	77,448		10			77,448	29
30	Building Additions			1992	89,051		10			89,051	30
31	Building Additions			1993	46,236	1,490	10	4,624	3,134	46,236	31
32	Building Additions			1994	220,966	14,241	10	22,097	7,856	213,846	32
33	Building Additions			1994	12,302	889	10	1,230	341	11,858	33
34	Building Additions			1994	1,430	103	10	143	40	1,378	34
35	Building Additions			1995	125,206	3,210	39	3,210	0	27,422	35
36	Curtains			1996	1,169	30	39		(30)	211	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Concrete Wall	1996	$ 2,785	$ 71	39	$ 71	$ 0	$ 500	37
38	Boiler Repair	1996	4,763	122	39	122	0	859	38
39	Windows	1996	10,000	256	39	256	0	1,803	39
40	Water Heater	1996	5,100	131	39	131	(0)	922	40
41	Water Line	1996	1,985	51	39	51	(0)	359	41
42	Sidewalk Repairs	1996	2,464	63	39	63	0	444	42
43	Storm Windows	1996	10,679	274	39	274	(0)	1,929	43
44	Electrical Circuit	1996	22,780	584	39	584	0	4,112	44
45	Elevator Selector	1996	2,632	67	39	67	0	472	45
46	House Pump	1996	22,527	578	39	578	(0)	4,071	46
47	Water Gate	1996	2,165	56	39	56	(0)	394	47
48	Air Conditioner Circuits	1997	6,845	176	39	176	(0)	1,136	48
49	Alarm Detectors	1997	634	16	39	16	0	108	49
50	Bathtub Refinish	1997	9,152	235	39	235	(0)	1,509	50
51	Bathroom Remodel	1997	5,135	132	39	132	(0)	874	51
52	Boiler Flame	1997	2,769	71	39	71		429	52
53	Ceiling Tiles	1997	623	16	39	16	(0)	106	53
54	Circuit Breakers	1997	1,920	49	39	49	0	313	54
55	Concrete	1997	1,300	33	39	33	0	216	55
56	Curtains	1997	749	19	39	19	0	126	56
57	Doorways	1997	6,660	171	39	171	(0)	1,062	57
58	Electrical	1997	1,361	35	39	35	(0)	211	58
59	Elevator	1997	42,595	1,092	39	1,092	0	7,478	59
60	Emergency Lights	1997	7,110	182	39	182	0	1,100	60
61	Fence	1997	4,500	115	39	115	0	733	61
62	Fire Alarm	1997	78,500	2,013	39	2,013	(0)	13,338	62
63	Flooring	1997	4,972	128	39	127	(1)	818	63
64	Kitchen Pipes	1997	2,200	56	39	56	0	348	64
65	Laundry Room	1997	24,750	634	39	635	1	4,272	65
66	Ramp Rail	1997	795	20	39	20	0	136	66
67	Remodeling	1997	141,653	3,632	39	3,632	0	22,840	67
68	Roof Repair	1997	14,458	371	39	371	(0)	2,520	68
69	Sensor Modules	1997	1,005	26	39	26	(0)	181	69
70	TOTAL (lines 4 thru 69)		$ 2,728,724	$ 31,438		$ 42,780	$ 11,342	$ 2,215,800	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,728,724	$ 31,438		$ 42,780	$ 11,342	$ 2,215,800	1
2	Water Valves	1997	1,060	27	39	27	0	179	2
3	Windows	1997	11,978	307	39	307	0	2,059	3
4	Bath Tub Refinish	1998	2,620	67	39	67	0	397	4
5	Blinds	1998	608	16	39	16	(0)	94	5
6	Electrical	1998	6,670	171	39	171	0	893	6
7	Elevator Remodel	1998	1,778	46	39	46	(0)	236	7
8	Emergency Lights	1998	10,323	265	39	265	(0)	1,557	8
9	Flooring	1998	1,600	41	39	41	0	224	9
10	Heat Pump	1998	1,213	31	39	31	0	161	10
11	Masonry/Electric	1998	11,660	299	39	299	(0)	1,507	11
12	Paneling	1998	1,116	29	39	29	(0)	158	12
13	Remodeling	1998	5,053	130	39	130	(0)	765	13
14	Replace pipes	1998	2,204	57	39	57	(0)	287	14
15	Roofing	1998	3,800	97	39	97	0	562	15
16	Spec. Consult	1998	232	6	39	6	(0)	30	16
17	Walk in Cooler	1998	11,565	297	39	297	(0)	1,646	17
18	Windows	1998	18,387	471	39	471	0	2,558	18
19	Wiring	1998	4,787	123	39	123	(0)	671	19
20	Activity Area	1999	10,937	280	39	280	0	1,319	20
21	Air Cleaners	1999	8,338	213	39	214	1	961	21
22	Café Line	1999	5,927	152	39	152	(0)	678	22
23	Doors	1999	4,225	108	39	108	0	510	23
24	Drain Line	1999	950	24	39	24	0	115	24
25	Electrical Panel	1999	985	25	39	25	0	109	25
26	Fire Dumper	1999	37,670	966	39	966	(0)	4,791	26
27	Flooring	1999	1,304	33	39	33	0	153	27
28	Heater Booster	1999	2,521	65	39	65	(0)	311	28
29	Masonry/Tuckpoint	1999	11,740	301	39	301	0	1,342	29
30	Renovate Elevator	1999	9,520	244	39	244	0	1,068	30
31	Roof Repair	1999	1,050	27	39	27	(0)	109	31
32	Spec. Consult	1999	2,474	64	39	63	(1)	315	32
33	Tubs & Valves	1999	5,422	139	39	139	0	579	33
34	TOTAL (lines 1 thru 33)		$ 2,928,441	$ 36,559		$ 47,901	$ 11,342	$ 2,242,144	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,928,441	$ 36,559		$ 47,901	$ 11,342	$ 2,242,144	1
2	Windows	1999	30,303	777	39	777		3,462	2
3	Air Cleaners	2000	3,900	100	39	100		379	3
4	Bathroom Valve	2000	1,894	49	39	49	(0)	186	4
5	Carpeting	2000	749	19	39	19	0	58	5
6	CPU Power	2000	5,580	143	39	143	0	542	6
7	Door Parts	2000	1,724	44	39	44	0	152	7
8	Electrical Panel	2000	2,305	59	39	59	0	208	8
9	Elevator Switch	2000	2,300	59	39	59	(0)	204	9
10	Fire Alarm Pump	2000	1,700	44	39	44	(0)	167	10
11	Fire Code Improvement	2000	8,131	208	39	208	0	789	11
12	Fire Damper	2000	5,620	144	39	144	0	486	12
13	Fire System	2000	66,705	1,710	39	1,710	0	6,343	13
14	Hand Rails	2000	6,602	169	39	169	0	576	14
15	Masonry	2000	11,840	304	39	304	(0)	1,193	15
16	Paint & Drywall	2000	12,400	318	39	318	(0)	1,180	16
17	Remodel Fire Pump Room	2000	3,100	79	39	79	0	260	17
18	Remodel Laundry Room	2000	3,500	90	39	90	(0)	296	18
19	Remodeling	2000	15,441	396	39	396	(0)	1,458	19
20	Remove Walls	2000	9,600	246	39	246	0	851	20
21	Shower Valves	2000	4,650	119	39	119	0	412	21
22	Sprinkler	2000	689	18	39	18	(0)	68	22
23	Steam Line	2000	2,734	70	39	70	0	271	23
24	Windows	2000	24,967	640	39	640	0	1,985	24
25	Heat Detectors	2001	880	23	39	23	(0)	62	25
26	Fire Alarm	2001	1,320	34	39	34	(0)	92	26
27	Pipe Add On Devises	2001	880	23	39	23	(0)	62	27
28	Pipe Add On Devises	2001	1,320	34	39	34	(0)	92	28
29	Fire Alarm	2001	1,997	51	39	51	0	138	29
30	Heat Detectors	2001	1,721	44	39	44	0	119	30
31	Heat Detectors	2001	990	25	39	25	0	68	31
32	Heat Detectors	2001	660	17	39	17	(0)	46	32
33	Water Heater	2001	4,950	127	39	127	(0)	344	33
34	TOTAL (lines 1 thru 33)		$ 3,169,593	$ 42,742		$ 54,085	$ 11,343	$ 2,264,693	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,169,593	$ 42,742		$ 54,085	$ 11,343	$ 2,264,693	1
2	Wood Door	2001	570	15	39	15	(0)	40	2
3	Wood Door	2001	570	15	39	15	(0)	40	3
4	HVAC	2001	36,200	928	39	928	0	2,437	4
5	Heat Detectors	2001	2,660	68	39	68	0	179	5
6	Fire Alarm	2001	1,320	34	39	34	(0)	89	6
7	Panel	2001	440	11	39	11	0	29	7
8	Testing	2001	660	17	39	17	(0)	45	8
9	Plumbing	2001	4,050	104	39	104	(0)	273	9
10	Electrical	2001	1,180	30	39	30	0	79	10
11	Masonry	2001	2,450	63	39	63	(0)	160	11
12	Cubicle Curtains	2001	1,225	31	39	31	0	76	12
13	Reroof	2001	8,080	207	39	207	0	509	13
14	Elevator Repair	2001	17,412	446	39	446	0	1,097	14
15	Fencing	2001	4,000	103	39	103	(0)	245	15
16	Electrical	2001	2,485	64	39	64	(0)	152	16
17	Excavating/Paving	2001	28,083	720	39	720	0	1,590	17
18	Windows	2001	18,400	472	39	472	(0)	1,003	18
19	Windows	2001	2,900	74	39	74	0	157	19
20	Boiler Parts	2001	3,148	81	39	81	(0)	172	20
21	Iron Gate	2001	1,725	44	39	44	0	94	21
22	Front Walk	2001	2,950	76	39	76	(0)	161	22
23	Electrical	2001	7,528	193	39	193	0	394	23
24	Shower Room	2001	24,500	628	39	628	0	1,282	24
25	Water Heater	2001	4,950	127	39	127	(0)	259	25
26	Generator	2001	3,500	90	39	90	(0)	184	26
27	Plumbing	2001	1,340	34	39	34	0	69	27
28	Plumbing	2001	1,485	38	39	38	0	78	28
29	Plumbing	2001	1,635	42	39	42	(0)	86	29
30	Plumbing	2001	578	15	39	15	(0)	31	30
31	Smoke & Stobe Add ons	2001	16,979	435	39	435	0	905	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,372,596	$ 47,947		$ 59,290	$ 11,343	$ 2,276,608	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,372,596	$ 47,947		$ 59,290	$ 11,343	$ 2,276,608	1
2	Water Heater	2002	4,433	114	39	114	(0)	223	2
3	Roof Repair	2002	3,870	99	39	99	0	169	3
4	Remodel Weight Room	2002	4,200	108	39	108	(0)	184	4
5	Remove Fire Escapes	2002	5,600	144	39	144	(0)	210	5
6	Electrical Work	2002	4,240	109	39	109	(0)	132	6
7	Plumbing Café	2002	15,294	392	39	392	0	441	7
8	Wiring Panels	2002	10,970	281	39	281	0	316	8
9	Wiring	2002	2,965	76	39	76	0	79	9
10	Replace Water Heater	2002	5,037	129	39	129	0	134	10
11	Steam Heat Repair	2002	3,370	86	39	86	0	126	11
12	Tuckpoint	2002	5,600	144	39	144	(0)	174	12
13	Kitchen Hood Fire Suspension	2003	2,819	69	39	72	3	69	13
14	Sewer Pipe	2003	3,287	81	39	84	3	81	14
15	Tile	2003	512	13	39	13	0	13	15
16	Pipe Replacement	2003	752	17	39	19	2	17	16
17	Air Conditioning Work	2003	5,130	115	39	132	17	115	17
18	Fence	2003	1,380	28	39	35	7	28	18
19	Roof Repair	2003	10,250	121	39	263	142	121	19
20	AC Compressor	2003	7,800	92	39	200	108	92	20
21	Breaker Panels	2003	18,986	183	39	487	304	183	21
22	Electrical Work	2003	5,420	17	39	139	122	17	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,494,511	$ 50,365		$ 62,416	$ 12,051	$ 2,279,532	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 58,402	$ 3,751	$ 8,587	$ 4,836	5-7	$ 54,320	71
72	Current Year Purchases	19,507	19,507	2,838	(16,669)	5-7	19,507	72
73	Fully Depreciated Assets	970,856		13,585	13,585	5-7	970,856	73
74								74
75	TOTALS	$ 1,048,765	$ 23,258	$ 25,010	$ 1,752		$ 1,044,683	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Chevy Blazer 1997	2000	$ 21,295	$ 1,775	$ 4,259	$ 2,484	5	$ 10,690	76
77	Facility	Nissan Pathfinder 2001	2002	26,104	4,900	5,221	321	5	12,560	77
78	Facility	Ford Van 2003	2002	28,925	4,900	5,785	885	5	12,560	78
79										79
80	TOTALS			$ 76,324	$ 11,575	$ 15,265	$ 3,690		$ 35,810	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,875,768	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,198	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 102,691	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,493	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,360,025	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Barton Management - Allocation				17,173			5
6								6
7	TOTAL				$ 17,173 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description: Schedule Attached $19,654
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Central Plaza Residential Home **#** 0017038 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,318,131	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	436,069		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	186,974		6
7	Other Prepaid Expenses	81,908		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	1,423		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,024,505	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	256,168		13
14	Buildings, at Historical Cost	3,574,398		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,045,197		16
17	Accumulated Depreciation (book methods)	(3,394,742)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Rush Barton Investment	320,461		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,801,482	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,825,987	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,608	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	120,366		29
30	Accrued Salaries Payable	52,716		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,311		31
32	Accrued Real Estate Taxes(Sch.IX-B)	170,896		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 467,897	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,024,964		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,024,964	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,492,861	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,333,126	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,825,987	$	48

***(See instructions.)**

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,946,404	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,946,404	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	786,722	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(400,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 386,722	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,333,126	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,659,046	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,659,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	53,713	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,713	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	574	28
28a	Phone Commissions	500	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,074	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,713,833	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,717,178	31
32	Health Care	2,533,659	32
33	General Administration	3,001,699	33
	B. Capital Expense		
34	Ownership	532,225	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	142,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,927,111	40
41	**Income before Income Taxes (line 30 minus line 40)****	786,722	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 786,722	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,160	2,313	$ 69,450	$ 30.03	1
2	Assistant Director of Nursing	744	753	19,540	25.95	2
3	Registered Nurses	3,223	3,404	84,479	24.82	3
4	Licensed Practical Nurses	19,793	22,374	372,338	16.64	4
5	Nurse Aides & Orderlies	69,510	78,643	664,467	8.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,716	10,444	82,259	7.88	10
11	Social Service Workers	40,209	44,619	636,345	14.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,837	29,627	258,655	8.73	15
16	Dishwashers					16
17	Maintenance Workers	21,052	22,686	264,487	11.66	17
18	Housekeepers	35,461	39,408	287,113	7.29	18
19	Laundry					19
20	Administrator	2,080	2,080	80,044	38.48	20
21	Assistant Administrator	2,080	2,080	43,437	20.88	21
22	Other Administrative	7,000	7,000	308,899	44.13	22
23	Office Manager					23
24	Clerical	14,023	18,838	421,503	22.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,873	2,167	25,401	11.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	254,761	286,436	$ 3,618,417 *	$ 12.63	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	327	$ 13,480		35
36	Medical Director	136	4,200		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	138	4,840		44
45	Social Service Consultant	289	12,994		45
46	Other(specify)				46
47	Psychiatric	118	6,000		47
48	Psychological	190	8,560		48
49	TOTAL (lines 35 - 48)	1,294	$ 51,874		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	111	$ 4,233		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	111	$ 4,233		53

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gwen Washington	Administrator	0	$ 80,044
Dora Maria Green	Admin Assisst	0	43,437
Arnie Kanter	Administrative	0	48,360
Joe Magit	Administrative	6.8	60,000
John Shlofrock	Administrative	8.8	87,981
Rick Duros	Administrative	0	58,456
Gary Weintraub	Administrative	0	54,102
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 432,380

B. Administrative - Other

Description	Amount
Management Fees (Adjusted out on page 5)	$ 862,365
TOTAL (agree to Schedule V, line 17, col. 3)	$ 862,365
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Lawrencewood Financial	Accounting	$ 4,500
Pension Performance	Accounting	1,110
Bisys	Accounting	1,600
Alpha Data Services	Data Processing	4,541
Omnicare Of Northern IL	Computer Service	200
Barton Management Allocation	Computer Service	5,536
Enloe Drugs	Computer Service	800
Personnal Planner	Unemployment Consult	1,791
Career Advancement Consul	Other Professional Serv	13,250
Barton Management Allocation	Legal	658
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,986

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,860
Unemployment Compensation Insurance	49,120
FICA Taxes	255,853
Employee Health Insurance	258,583
Employee Meals	29,812
Illinois Municipal Retirement Fund (IMRF)*	
Employee Head Tax	5,632
Employee Benefits -Other	7,010
TOTAL (agree to Schedule V, line 22, col.8)	$ 676,870

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 7,200
Advertising: Employee Recruitment	6,791
Health Care Worker Background Check	415
(Indicate # of checks performed 59.3)	
Dues - IL Council LTC	10,122
Misc Dues & Subs & Licenses	1,428
City of Chicago License	1,000
Franchise Tax	50
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,006

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,384
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,384

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Decorating	12/00	$ 4,257	3	$ 1,419	$ 1,419	$ 1,419	$	$	$	$	$	$
2	Decorating	12/01	3,819	3		1,273	1,273	1,273					
3	Decorating	12/02	2,652	3			884	884	884				
4	Decorating	12/03	1,225	3				408	408	409			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,953		$ 1,419	$ 2,692	$ 3,576	$ 2,565	$ 1,292	$ 409	$	$	$

Facility Name & ID Number Central Plaza Residential Home **#** 0017038 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Only CNA's**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **n/a** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **142,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **29,812** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **no**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.